Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DOLLY VINSANT MEMORIAL HOSPITAL 302 KINGS HWY STE 112 BROWNSVILLE TX 78521-4224	MFDR Tracking #: M4-05-A197-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO. Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our position is that he billing in dispute has not been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies, rules, and the Texas Labor Code. The TWCC has not assigned Maximum Allowable Rates for the services the subject of this claim… In support of our position, Dolly Vinsant has previously submitted copies of redacted EOBs from other carriers that establish fair and reasonable rates paid by carrier's for similar medical services performed in this locality and geographical area… Furthermore, Dolly Vinsant asserts that no contractual relationship exist between it and Rockport Healthcare Group."

Amount in Dispute: $9,220.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Workers' Compensation Commission contracted with Ingenix to develop hospital outpatient payment fee guideline. The Texas Workers' Compensation Commission Ingenix Summary 2002 (Exhibit 3) recommends overall market reimbursement level of 140% of the Medicare Hospital Prospective Payment System (HOPPS) as a fair and reasonable reimbursement in accordance with Section 413.011(d) of the Texas Labor Code. 140% of the HOPPS for the procedures in dispute would result in reimbursement in the amount of $1,069.08. This carrier had reimbursed the requester $340. Therefore this carrier has made additional reimbursement in the amount of $729.08 for total reimbursement of $1,069.08, and no further reimbursement is due… As supported above, it is this carrier's position that the amount billed, $9,560.00 is not fair or reasonable… We attempted to settle this based on Ingenix recommendation to the Commission and the provider refused."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/9/2004	M, 894, 713, 793, 790, W4, 143, 24, 420, 891, W1, 920	Outpatient Surgery	$9,220.00	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on July 7, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 15, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - M – No MAR
   - 894 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE "O/R SERVICE" LINE ITEM.

- 713 - FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.
- 793 – REDUCTION DUE TO PPO CONTRACT.
- 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY ROCKPORT HEALTHCARE GROUP NETWORK PARTNER ROCKPORT HEALTHCARE GRP. FOR PROVIDER SUPPORT 1-800-635-9810.
- 790 – THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 143 – PORTION OF PAYMENT DEFERRED.
- 24 – PAYMENT FOR CHARGES ADJUSTED. CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.
- 420 – SUPPLEMENTAL PAYMENT.
- 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERING A BILL.
- W1 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 920 – REIMBURSEMENT IS BEING ALLOWED BASED UPON A DISPUTE.

2. According to the submitted explanations of benefits, the insurance carrier reduced or denied disputed services with reason codes 24 – "PAYMENT FOR CHARGES ADJUSTED. CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN." and 793 – "REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY ROCKPORT HEALTHCARE GROUP NETWORK PARTNER ROCKPORT HEALTHCARE GRP. FOR PROVIDER SUPPORT 1-800-635-9810." Review of the submitted information found no documentation to support the existence of a contractual agreement between the parties to this dispute. On November 5, 2010, the Division requested the respondent to provide a copy of the referenced contract between the network and the health care provider, pursuant to Division rule at 28 TAC §133.307(l), which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." The respondent failed to provide a copy of the additional requested documents. The respondent has not supported the above denial/reduction explanations. For this reason, the disputed services will be reviewed in accordance with applicable Division fee guidelines.
3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the documentation submitted by the requestor finds that the requestor has not provided medical records to support the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit documentation of the radiology report(s), anesthesia record, nursing/recovery notes, EKG report, or other documentation to support the services as billed. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement states that "In support of our position, Dolly Vinsant has previously submitted copies of redacted EOBs from other carriers that establish fair and reasonable rates paid by carrier's for similar medical services performed in this locality and geographical area."

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement.
- In support of the requested reimbursement, the requestor submitted three redacted EOBs that the requestor asserts are for similar medical services performed in the same locality and geographical area. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The redacted EOBs indicate that payment was reduced based on the insurance carriers' fair and reasonable reimbursement methodology; however, the carriers' fair and reasonable reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The Division has previously found that a reimbursement methodology based on hospital costs does not produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

  "The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models… are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs… Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs."
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(B), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Insurance Code Chapter 1305, §1305.006, §1305.153
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	**2/2/2011**
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.